TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Trumbull Insurance Company

**MFDR Tracking Number**
M4-17-2191-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
March 20, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The attached bill was denied medication not authorized. Reconsideration was sent on two separate occasions with no response for the reconsideration. We are now requesting Medical Fee Dispute Resolution."

**Amount in Dispute:** $602.67

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The bill has been disputed as there was no prior authorization."

**Response Submitted by:** Broadspire

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 31, 2016 | Pharmacy Services – Compound | $602.67 | $602.67 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.500 defines terms used in pharmaceutical billing.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Denied – Medication Not Authorized

**Issues**

1. Is Trumbull's denial of payment for the disputed service supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed service?

**Findings**

1. Memorial is seeking reimbursement of $602.67 for a compound cream dispensed on May 31, 2016. Trumbull Insurance Company (Trumbull) denied the disputed service stating, "Denied – Medication Not Authorized." 28 Texas Administrative Code §134.500(3) defines the closed formulary as "all Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use" except those requiring preauthorization. 28 Texas Administrative Code §134.530(b)(2) states:

   Preauthorization is only required for:
   (A) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   The division finds that the ingredients noted in the compound in question are included in the division's closed formulary as the ingredients consist of FDA approved drugs and inactive ingredients and do not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Trumbull failed to articulate any defenses for denial of the disputed compound for this reason. Therefore, the division concludes that the compound in question did not require preauthorization and Trumbull's denial for this reason is not supported.

2. 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
      (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
         (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
         (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
         (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
      (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
         (A) health care provider; or
         (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

| Ingredient | NDC & Type | Price/ Unit | Total Units | AWP Formula §134.503(c)(1) | Billed Amt §134.503 (c)(2) | Lesser of (c)(1) and (c)(2) |
|---|---|---|---|---|---|---|
| Amitriptyline HCl | 38779018904 Generic | $18.24 | 2.4 gm | $18.24 x 2.4 x 1.25 = $54.72 | $42.17 | $42.17 |
| Gabapentin USP | 38779246109 Generic | $59.85 | 3.0 gm | $59.85 x 3 x 1.25 = $224.44 | $156.75 | $156.75 |
| Flurbiprofen | 38779036209 Generic | $36.58 | 4.8 gm | $36.58 x 4.8 x 1.25 = $219.48 | $168.72 | $168.72 |
| Amantadine HCl | 38779041105 Generic | $24.225 | 4.8 gm | $24.225 x 4.8 x 1.25 = $145.35 | $61.58 | $61.58 |
| Ethoxy Diglycol | 38779190301 Generic | $0.342 | 3.6 ml | $0.342 x 3.6 x 1.25 = $1.54 | $1.23 | $1.23 |
| Bupivacaine HCl | 38779052405 Generic | $45.60 | 1.2 gm | $45.60 x 1.2 x 1.25 = $68.40 | $48.02 | $48.02 |
| Versapro Cream Bas | 38779252903 Brand Name | $3.20 | 43.68 gm | $3.20 x 43.68 x 1.25 = $174.72 | $109.20 | $109.20 |
| Compounding Fee | NA | NA | NA | $15.00 | $15.00 | $15.00 |
| | | | | | Total | $602.67 |

The total allowable reimbursement for the disputed service is $602.67. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $602.67.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $602.67, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Laurie Garnes<br>Medical Fee Dispute Resolution Officer | May 30, 2017<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.